

# CHILD CARE NEED FORM

Please complete if you would like a list of child care providers who are licensed or registered by the State of Montana. The information provided is for referral purposes only. HRDC-Child Care Link does not warrant the information concerning any provider, nor do we license, endorse, or recommend any particular provider. Only you can determine whether the quality of care is appropriate for your child by thorough screenings and visits with the provider prior to care being provided. Please make an appointment for further information on selecting appropriate care.

Today's Date \_\_\_\_\_ Is this the first time you have received a referral?  Yes  No

Parent(s) Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Other \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Spouse/Partner's Employer \_\_\_\_\_

**Care is Requested**

- Near home     
  Near work     
  Near parents' school:  
 Near child's school   
  No preference   
  Other:

Please complete the following information for all children needing child care:

<u>Name</u>	<u>Date of Birth</u>	<u>Days</u>	<u>Times</u>
		<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su	_____ - _____
		<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su	_____ - _____
		<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su	_____ - _____
		<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su	_____ - _____

Starting date care is needed \_\_\_\_\_

**Other scheduling needs, check all that apply**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Full-time (30+ hrs/week)     | <input type="checkbox"/> Drop in care       | <input type="checkbox"/> 24-hour care         |
| <input type="checkbox"/> Part-time (less than 30 hrs) | <input type="checkbox"/> Before school care | <input type="checkbox"/> After school care    |
| <input type="checkbox"/> Full year care               | <input type="checkbox"/> Rotating schedule  | <input type="checkbox"/> Temp./emergency care |
| <input type="checkbox"/> School year only             | <input type="checkbox"/> Summer only        |   |

**What type of facility are you looking for?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Child Care Center<br>(13 or more children) | <input type="checkbox"/> Family Child Care<br>(3 -6 children)     | <input type="checkbox"/> Preschool (1/2 day, usually<br>not licensed) |
| <input type="checkbox"/> School Age Program                         | <input type="checkbox"/> Group Home Child<br>Care (3-12 children) | <input type="checkbox"/> Summer Program                               |

**Do you have any Needs/ Preferences regarding Environment?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Provider will toilet train          | <input type="checkbox"/> Offers field trips | <input type="checkbox"/> Wheelchair accessible           |
| <input type="checkbox"/> No pets at facility                 | <input type="checkbox"/> Outdoor activities | <input type="checkbox"/> Uses a structured<br>curriculum |
| <input type="checkbox"/> Outdoor play equipment              | <input type="checkbox"/> No TV              | <input type="checkbox"/> Non smoking facility            |
| <input type="checkbox"/> Does not use vehicle transportation |   |  |

**Does your child have any special needs that may require accommodation?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADHD/ADD                      | <input type="checkbox"/> Autism                  | <input type="checkbox"/> Catheter         |
| <input type="checkbox"/> Downs Syndrome                | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> Vision impaired               | <input type="checkbox"/> Seizures                | <input type="checkbox"/> Cerebral Palsy   |
| <input type="checkbox"/> Tube feeding                  | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Developmentally  |
| <input type="checkbox"/> Fetal alcohol effect/syndrome | <input type="checkbox"/> Emotional/Mental health |   |

**COMPLETE THIS AREA ONLY IF NEEDED**

**Transportation Needs**

- |   |  |
|---|--|
| <input type="checkbox"/> I require transportation from provider               | <input type="checkbox"/> I rely on public transportation |
| <input type="checkbox"/> I need child care to be walking distance from school |  |

**If you require transportation from your child care provider, please specify need.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> To/from Kindergarten       | <input type="checkbox"/> before and after school   | <input type="checkbox"/> To/from child's home |
| <input type="checkbox"/> To/from child's activities | <input type="checkbox"/> Transportation for family |   |

**What school(s) does your child(ren) attend?** \_\_\_\_\_

**Who is providing your current care?**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Family/group child care     | <input type="checkbox"/> Child care center | <input type="checkbox"/> Head Start |
| <input type="checkbox"/> Family member               | <input type="checkbox"/> Friend            | <input type="checkbox"/> Nanny      |
| <input type="checkbox"/> No current care             | <input type="checkbox"/> Preschool         | <input type="checkbox"/> LUP/LUI    |
| <input type="checkbox"/> Before/after school program |  |                                     |

**Do you receive child care payment assistance?**

- |  |  |                                  |
|--|--|----------------------------------|
| <input type="checkbox"/> Best Beginnings Scholarship | <input type="checkbox"/> FAIM          | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Tribal Block Grant          | <input type="checkbox"/> No assistance |                                  |

Would you like information regarding child care payment assistance?  Yes  No

What is your family size? (Number of adults and children in your household) \_\_\_\_\_

Single Adult In Household  Two or More Adults In Household

How did you learn about our services?

- Employer  Friend/relative  Previous user  
 Media-newspaper, radio, TV  Brochure/poster  Community agency  
 Phone book-yellow pages  Tribal program  Internet/website  
 Child Care Provider

What is your reason for seeking child care?

- Work  Looking for work  School/training  
 Respite care  Child's need  Parent's need  
 Current care closing  Current cost too high  Unhappy with quality of current care  
 Asked to leave current arrangement

Would you like a personal consultation on selecting quality child care?  Yes  No

If yes, please contact receptionist to make appointment with Shawna.

Would you like any parenting or child development information? Please specify \_\_\_\_\_

I would like to have my referral list: (check one)

- Mailed to me at the address listed  E-mailed to me at the e-mail listed  
 I will pick it up. Please list date and time \_\_\_\_\_

For office use only

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Referral counselor \_\_\_\_\_ Date referral sent \_\_\_\_\_ Fee \$ \_\_\_\_\_